significant differences in pts survival (one death in each group) Graft loss was higher in G1(4 versus 1 at 12 months p= 0.014). there were no significant differences in respect to liver, respiratory, GI, hematologic and infectious complications. pts in G2 group had lower BP and uric acid levels.

CONCLUSIONS: Conversion to mTOR inhibitors in more advanced stages of CAN is safe and has beneficial effect on renal allograft function with no more side effect.

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CONVERSION FROM CALCINEURIN INHIBITORS TO SIROLIMUS IN ADVANCED STAGES OF CHRONIC ALLOGRAFT NEPHROPATHY: IS IT BENEFICIAL

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INTRODUCTION: Mammalian target of rapamycin (mTOR) inhibitors are considered an alternative immunosuppressive treatment that can prevent the nephrotoxicity that is associated with calcineurin inhibitor-based immunosuppressive regimens. some studies have shown that proteinuria more than 800 mg per day and glomerular filtration rate (GFR) less than 40 ml/min are the most important relative contraindications for mTOR inhibitors prescription. There is no pathophysiologic reason to put aside mTOR inhibitors in more advanced stages of chronic allograft nephropathy(CAN). To clarify the safety of conversion to mTOR inhibitors in more advanced stages of CAN we conduct a randomized clinical trial.

METHODS: Among 1911 renal transplant recipients which was performed from May 1989 to May 2016, patients (pts) with CAN included to the study. CAN was defined by pathology results and rule out of other causes of renal dysfunction and GFR less than 60 ml/min . pts with recent acute rejection, chronic Ab mediated rejection, active viral infection, malignancy, advanced cardiac, liver and respiratory diseases, obstructive uropathy and non adherence were excluded from the study. After exclusion there were 211 pts with CAN. Among CAN pts 112 pts have GFR less than 40 ml/min. these pts were assigned in two group randomly. Group 1 continued their immunosuppression which consists of mycophenolate mofetil/myfortic, Cyclosporin A/Tacrolimus and prednisolone. Group B which recieved Sirolimus 2 mg daily instead of CyclosporinA/ tacroloimus. ALL pts followed for one year. allograft function and pts morbidity and mortality were monitored every two months. results were recorded in clinic sheets and were analyzed using SPss version 22.

RESULTS: G1 consist of 53 and G2 59 pts. There were no differences in two group in respect to sex (M/F was 0.89 and 0.84 in G1 and G2 respectively), and age (mean age was 41 $\pm$ 9.5 and 43 $\pm$ 8.23 in G1 and G2 respectively). there were no differences in admission rate for medical reasons (0.43 and 0.39 admission per pts per year in G1 and G2 respectively p=0.23). There was no differences between two group in respect to cardiovascular events (0.23 and 0.27 events per pts per year in G1 and G2 respectively p=0.31). The average trough level of SRL was 7.38 $\pm$ 3.74 ng/mL at 12 months. At 12 months, the incidence of acute rejection was not higher in G2 (14 vs. 11.8 %, p = 0.21) and renal function was superior in patients converted to SRL (32.3 vs. 23.4 mL/min/ 1.73 m2, p = 0.019) compared to those maintained on CsA/TAC. there were no